Oakwood City School District

Health Information Form

Dear Parent/Guardian,

Please complete the following health questionnaire regarding your student. The information will be reviewed by the school nurse and shared with school personnel as necessary.

Student name: _____ Birthdate: _____

Grade/Teacher: _____

Does your student have?
Asthma _____ Seizure Disorder _____ Heart Disease _____ Other _____
Diabetes _____ ADD/ADHD _____ Cancer _____

Does your student have food, inhalant, or stinging insect allergies? Yes ____ No ____
If yes, please describe reaction and medications used: _____

_____

Does student have a physical disability and/or limitation? Yes ____ No _____

Explain: _____

Please list all medications you student takes on a regular basis and why? _____

_____

Will he /she need to take medication during the school hours? Yes ____ No ____
(If yes, please request a Permission to Administer Medication Form From Your School Office or go to our website www.oakwoodschools.org under clinic forms)

Does your student wear glasses? Yes ____ No ____ Contact lenses? Yes ___ No ___

Does your student have hearing loss? Yes ____ No ____ Hearing aid? Yes ___ No ___

Please list any other health history or medical information that school personnel should be aware of: _____

_____

_____

_____ _____
Parent/Guardian Signature Date